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FOR STATE  
HEALTH DEPT

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
2898 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										02880	
1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> <b>MARYLAND</b>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CAROLINE</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>				c. LENGTH OF STAY IN 1b <b>life</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>				d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS <b>1</b>					
3. NAME OF DECEASED (Type or print) <b>NORA</b>			First <b>NORA</b> Middle <b>ANDERSON</b> Last <b>ANDERSON</b>			4. DATE OF DEATH <b>MAR. 9</b>			Month <b>9</b> Day <b>19</b> Year <b>61</b>		
5. SEX <b>F</b>		6. COLOR OR RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT 6, 1897</b>		9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13. FATHER'S NAME <b>Louis Anderson</b>						14. MOTHER'S MAIDEN NAME <b>Martina Hopkins</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>Mrs Wayne Cowley Sr. Denton</b> Address <b>Denton</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Heart disease</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <b>Diabetes Mellitus</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs - 2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Dawson &amp; George</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <b>3-11-61</b>		
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>Mar 12, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul</b>			22d. LOCATION (City, town, or country) (State) <b>Near Denton, Md</b>			
23. FUNERAL DIRECTOR <b>Winget Moore How Denton</b> ADDRESS <b>Denton</b>						24a. REC'D BY REGISTRAR <b>DATE MAR 15 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>			

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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2899  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
02881

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>		c. LENGTH OF STAY IN 1b <u>10 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>North Main Street</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Bradley</u>		4. DATE OF DEATH Month <u>March</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 14, 1917</u>
9. AGE (In years lost birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Alexandria, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Timothy Milburn</u>		14. MOTHER'S MAIDEN NAME <u>Betty E. Breeding</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>James E. Bradley, Federalsburg, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>chronic myocarditis</u> DUE TO (c) <u>Essential Hypertension</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u> <u>5 yrs.</u> <u>5 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 3, 1961</u> , to <u>Mar 3, 1961</u> , that (I) (we) last saw the deceased alive on <u>Mar 3, 1961</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Frank M. Anderson</u>		22b. DATE <u>3-6-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank M. Anderson, M.D.</u>		22d. ADDRESS <u>Federalsburg, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 6, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>MAR 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>C. L. Hines</u>			

18250

RECORDS OF DEATH

18250

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02882

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIDGELY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RIDGELY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>GERTRUDE</u> First <u>CANNON</u> Middle <u>CANNON</u> Last		4. DATE OF DEATH <u>MARCH 22</u> Month <u>1961</u> Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 8, 1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>NOAH TURNER</u>		14. MOTHER'S MAIDEN NAME <u>CAROLINE TATMAN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Jas. Coually Denton, wid</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Dis.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchial Asthma</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mar. 4,</u> 19 <u>60</u> , to <u>Mar. 22</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Mar. 22</u> , 19 <u>61</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles H. Stonestifer</u>		ADDRESS (Street, city or town, state) <u>Greensboro, Md.</u> DATE SIGNED <u>3-23-61</u>	
PHYSICIAN'S NAME (Type) <u>Charles H. Stonestifer, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 24, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. H. Denton</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>APR 3 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	





# 1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

## MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 2901 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02883

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DENTON</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>DENTON</b> d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN HARVEY COLLINS</b>				4. DATE OF DEATH Month <b>MAR.</b> Day <b>2</b> Year <b>1961</b>					
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 31, 1885</b>	9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>76</b> Days	IF UNDER 24 HRS. Hours <b>76</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WOOD CUTTER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TIMBER</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>			
13. FATHER'S NAME <b>John Collins</b>				14. MOTHER'S MAIDEN NAME <b>Susan Trice</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. J. Harvey Collins Denton, MD</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangled Hernia</b> <b>561.5</b> DUE TO <b>Exposure</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <b>Exposure</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Rawson O. George</b>				M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>3-3-61</b>	
EXAMINER'S NAME (Type) <b>Rawson O. George M.D.</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Mar 5, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Concord</b>		22d. LOCATION (City, town, or country) (State) <b>Concord MD</b>			
23. FUNERAL DIRECTOR <b>Wingard</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>MAR 9 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

BP

3803 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1918

1918

1918



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2902

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02884

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HILLSBORO</u>		c. LENGTH OF STAY IN 1b <u>10 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WALTER MANNING DECKER</u>		4. DATE OF DEATH <u>Mar 16 19 61</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 16, 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Decker</u>		14. MOTHER'S MAIDEN NAME <u>Nancy Purvis</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Kenneth Decker</u>		Address <u>Queen Anne's head</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> <u>420.1</u> DUE TO <u>Coronary Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 yr</u> <u>7 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>General Atherosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 6</u> , 19 <u>55</u> , to <u>Mar 16</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>March 16</u> , 19 <u>61</u> , and that death occurred at <u>5 a.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Paul Knotts</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>E. Paul Knotts M.D.</u>		<u>Denton, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 20, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Upper Leake</u>		22d. LOCATION (City, town, or county) (State) <u>Upper Leake, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Edgar Moore</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 20 61</u>	
ADDRESS <u>Denton, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Christina L. Knott</u>	

(M)

X

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CERTIFICATE OF DEATH

2003

02446

<p>1. NAME OF DECEASED                  [Faint text, possibly "John Doe"]</p>		<p>2. SEX                  [Faint text, possibly "Male"]</p>	
<p>3. AGE                  [Faint text, possibly "45 years"]</p>		<p>4. DATE OF DEATH                  [Faint text, possibly "10/15/1918"]</p>	
<p>5. PLACE OF DEATH                  [Faint text, possibly "Home"]</p>		<p>6. CAUSE OF DEATH                  [Faint text, possibly "Pneumonia"]</p>	
<p>7. DISEASE OR INJURY                  [Faint text, possibly "Pneumonia"]</p>		<p>8. MANNER OF DEATH                  [Faint text, possibly "Natural"]</p>	
<p>9. SIGNATURE OF PHYSICIAN                  [Faint signature]</p>		<p>10. SIGNATURE OF REGISTRAR                  [Faint signature]</p>	
<p>11. PLACE OF BIRTH                  [Faint text, possibly "Maryland"]</p>		<p>12. DATE OF BIRTH                  [Faint text, possibly "10/15/1873"]</p>	
<p>13. OCCUPATION                  [Faint text, possibly "Farmer"]</p>		<p>14. MARITAL STATUS                  [Faint text, possibly "Married"]</p>	
<p>15. EDUCATION                  [Faint text, possibly "High School"]</p>		<p>16. RELIGION                  [Faint text, possibly "Roman Catholic"]</p>	
<p>17. PREVIOUS ILLNESS                  [Faint text, possibly "None"]</p>		<p>18. OTHER INFORMATION                  [Faint text, possibly "None"]</p>	

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THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH RECORDS AND VITAL STATISTICS ACT, CHAP. 1-101, § 1-102, AND § 1-103, OF THE MARYLAND CODE, 1915, AS AMENDED.

2903

02885

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>		b. COUNTY <b>Caroline</b>	
c. LENGTH OF STAY IN 1b <b>10 yr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>718 Gay St.</b>		d. STREET ADDRESS <b>718 Gay St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bertha Frances Luff</b>		4. DATE OF DEATH Month Day Year <b>March 10 1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cau.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>August 19, 1892</b>
9. AGE (In years last birthday) yrs. <b>68</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		12. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>	
13. BIRTHPLACE (State or foreign country) <b>Maryland</b>		14. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. FATHER'S NAME <b>No Record</b>		16. MOTHER'S MAIDEN NAME <b>No Record</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		18. SOCIAL SECURITY NO. <b>None</b>	
19. INFORMANT <b>John R. Luff, Jr.</b>		Address <b>Denton, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary thrombosis</b> DUE TO (c) <b>Coronary artery disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Several days</b> <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertensive cardio-vasc. disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>March 10, 1961</b> , that (I) (we) last saw the deceased alive on <b>March 10, 1961</b> , and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Kurt Lederer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>KURT LEDERER</b>		22d. ADDRESS <b>Queen Anne Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-13-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>		23d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Bouleais</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 14 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

05880

CERTIFICATE OF DEATH

0003



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, it should be executed by the Medical Director, or his designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death. Please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.

VS. A15ME  
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BY

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
2904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RIDGELY</b> c. LENGTH OF STAY IN 1b <b>3 Weeks</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b> d. STREET ADDRESS <b>20 DISNEY AVE.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>EMMA</b> First <b>CASSANDRA</b> Middle <b>MARTIN</b> Last 4. DATE OF DEATH <b>MAR 3 1961</b> Month <b>MAR</b> Day <b>3</b> Year <b>1961</b>							
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JAN 29, 1867</b>	
9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>HARFORD CO. MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>THOMAS S. DENBOW</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE STRIDEHOFF</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Mrs. Wm. Collison, Ridgely Md</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Heart Disease Sudden</b> DUE TO (b) <b>Illness of Several Months</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. <b>3</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Dawson O. George</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dawson O. George</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <b>3-3-61</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Mar 6, 1961</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Churchville Md</b>	
23. FUNERAL DIRECTOR <b>John H. Hearnsen</b> ADDRESS				24a. REC'D BY REGISTRAR <b>MAR 7 '61</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Huns</b>	

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Address of Edward M. ...  
St. Louis, Mo.

Edward M. ...  
St. Louis, Mo.



Reg. Dist. No. 02887

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 and 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2202 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1950		BALTIMORE, MD	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF BURIAL		DATE OF BURIAL	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		CATHOLIC CHURCH		JAN 18 1950	
FATHER		MOTHER		SPOUSE		CHILDREN		SIBLINGS		OTHER RELATIVES	
JAMES H. HARRIS		MARY H. HARRIS		JANE H. HARRIS		JOHN H. HARRIS		EDWARD H. HARRIS		MARGARET H. HARRIS	
EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		PREVIOUS ILLNESS		HISTORY OF DRUGS	
HIGH SCHOOL		CATHOLIC		DEMOCRAT		NONE		NONE		NONE	
DATE OF BIRTH		PLACE OF BIRTH		DATE OF ENTRY INTO U.S.		REASON FOR ENTRY		DATE OF DEPARTURE FROM U.S.		REASON FOR DEPARTURE	
JAN 15 1905		BALTIMORE, MD		JAN 15 1905		NATURAL		JAN 15 1905		NATURAL	
DATE OF DEATH		PLACE OF DEATH		DATE OF BURIAL		PLACE OF BURIAL		DATE OF EXAMINATION		PLACE OF EXAMINATION	
JAN 15 1950		BALTIMORE, MD		JAN 18 1950		CATHOLIC CHURCH		JAN 15 1950		BALTIMORE, MD	
SIGNATURE OF EXAMINER		TITLE OF EXAMINER		DATE OF EXAMINATION		PLACE OF EXAMINATION		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		LABORER		JAN 15 1950		BALTIMORE, MD		JAN 15 1950		BALTIMORE, MD	

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FOR STATE HEALTH DEPT  
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Form Pages 1, 2, and 3 to the General Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
2906 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u> c. LENGTH OF STAY in lb <u>1 HR</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Ridgely Church</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Queenstown</u> d. STREET ADDRESS <u>17 X 2</u>					
3. NAME OF DECEASED (Type or print) <u>Lillie Louise Miller</u>			4. DATE OF DEATH Month <u>3</u> Day <u>12</u> Year <u>1961</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 13, 1888</u>		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JAMES Dobson</u>			14. MOTHER'S MAIDEN NAME <u>EMMALINE Dobson</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>			16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Mr. Girard</u> Address <u>Queenstown, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis Acute</u> <u>422.02</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis Chronic</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>One yr -</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>  </u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>		20g. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>3-18-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CARMichael Cem</u>		22d. LOCATION (City, town, or country) <u>Queenstown</u> (State) <u>Md.</u>		22e. REC'D BY REGISTRAR <u>  </u> 22f. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	
23. FUNERAL DIRECTOR <u>James B. Shull</u>			ADDRESS <u>Easton, Md.</u>		DATE <u>MAR 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

Item 9 & 8 Film G283 3/23/61 iwk  
**CERTIFICATE OF DEATH**

Reg. Dist. No. **02889**

1. PLACE OF DEATH a. COUNTY <b>CAROLINE</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CAROLINE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DENTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>LACY</b> First <b>CAIN</b> Middle <b>MURPHY</b> Last		4. DATE OF DEATH <b>MAR 12 1961</b> Month <b>MAR</b> Day <b>12</b> Year <b>1961</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug. 9, 1889</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STOCK DEALER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CATTLE</b>	9. AGE (In years last birthday) <b>71</b> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Murphy</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Lewis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>420.1</b>	
17. INFORMANT <b>Mrs. Daisy Murphy Denton, Md.</b> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Atherosclerosis</b> DUE TO (b) <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>general atherosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 25 1959</b> to <b>March 12 1961</b> , that I last saw the deceased alive on <b>March 10 1961</b> , and that death occurred at <b>10:15 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>E. Paul Knotts</b>		M.D.	
PHYSICIAN'S NAME (Type) <b>E. Paul Knotts M.D.</b>		<b>Denton, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Mar 15, 1961</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Concord</b>		22d. LOCATION (City, town, or county) (State) <b>Denton, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Nigel Moore &amp; Son</b> ADDRESS <b>Denton</b>		24a. REC'D BY REGISTRAR <b>MAR 20 '61</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

2908 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02890

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Goldsboro</b>		c. LENGTH OF STAY IN 1b <b>25 yr</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Goldsboro</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>None</b>				d. STREET ADDRESS <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Percy</b> <b>Peirce</b>				4. DATE OF DEATH <b>March</b> <b>14</b> <b>19 61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 15, 1880</b>	
9. AGE (In years last birthday) <b>80</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Peirce</b>				14. MOTHER'S MAIDEN NAME <b>No Record</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mattie Bordley Goldsboro, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis Generalized</b> <b>450.0</b> DUE TO <b>Heart &amp; Kidney Complications</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Heart &amp; Kidney Complications</b> DUE TO (c) <b>Heart &amp; Kidney Complications</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs 6 mos</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Dawson O. George</b> EXAMINER'S NAME (Type)				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>3-15-61</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3-17-61</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Roseville</b>		22d. LOCATION (City, town, or county) (State) <b>Ingleside Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaie</b> ADDRESS <b>Greensboro, Md.</b>				24a. REC'D BY REGISTRAR <b>MAR 16 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kimes</b>	

10-24-80  
MAYLAND STATE DEPARTMENT OF HEALTH-CALCULUS 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF DEATH		6. TIME OF DEATH		7. PLACE OF DEATH		8. CAUSE OF DEATH		9. MANNER OF DEATH		10. SIGNATURE OF EXAMINER		11. DATE OF EXAMINATION		12. SIGNATURE OF WITNESS		13. DATE OF SIGNATURE	

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the attending physician or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2909  
CERTIFICATE OF DEATH  
02891

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ridgely</b>		c. LENGTH OF STAY IN 1b <b>50 yr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Zoe</b> Middle <b>Powell</b> Last <b>Powell</b>		4. DATE OF DEATH Month <b>March</b> Day <b>3</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1889</b>
9. AGE (In years lost birthday) yrs. <b>71</b>		10. IF UNDER 1 YEAR Months Days Hours Min. <b>71</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm Laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles H. Powell</b>		14. MOTHER'S MAIDEN NAME <b>No Record</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-22-8767</b>	
17. INFORMANT <b>Anna Davenport</b>		Address <b>Ridgely, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Advanced Generalized Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb. 10, 1961</b> to <b>Mar. 3, 1961</b> that (I) (we) last saw the deceased alive on <b>Mar. 3, 1961</b> , and that death occurred <b>11:30 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Stonesifer</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>		22d. ADDRESS <b>Greensboro, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-6-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Chapel</b>		23d. LOCATION (City, town, or county) (State) <b>Rural Cardova Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulosis</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 9 '61</b>	
ADDRESS <b>Greensboro, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

08850

STATE OF TEXAS

1903

IN SENATE,  
January 14, 1903.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
FOR THE YEAR  
1902.  
BY  
J. M. HARRIS,  
COMMISSIONER.  
ALBUQUERQUE,  
NEW MEXICO,  
1903.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 02892

2910

Item 1b Film G282 3/17/61 mh

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Denton</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Denton, Randolph Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick J. Schlegel</u> First Middle Last		4. DATE OF DEATH <u>March 10 1961</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 3 1897</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Feed mill</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Schlegel</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Cohen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs Fred Schlegel</u> Address <u>Denton</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Heart Disease</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Occlusion</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 mos - Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Danson &amp; George</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>DANSON &amp; GEORGE</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Mar 12 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton Cemetery, Md</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. Brown &amp; Son</u> ADDRESS		24a. REC'D BY REGISTRAR <u>MAR 12 1961</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please see the instructions on the reverse side of this certificate. The word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAR 15 '61

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11529

*[Faint, mostly illegible handwritten text and markings are visible throughout the form, including what appears to be a signature in the upper right and various notations in the lower sections.]*

*[Faint vertical text on the left side of the form, possibly a date or file number, is partially legible.]*



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

2911

CERTIFICATE OF DEATH

02893

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Greensboro</b>		c. LENGTH OF STAY IN 1b <b>23 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Jesse C. Smith</b>		4. DATE OF DEATH Month <b>3</b> Day <b>18</b> Year <b>1961</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-5-1891</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>13</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales Rep. Pet Milk Co. Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Missouri</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Smith</b>		14. MOTHER'S MAIDEN NAME <b>Dora Null</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW 1 509-09-8185</b>	
17. INFORMANT <b>Mrs. Mabel Smith Greensboro, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Peptic Ulcer</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Mar. 4, 1961</b> to <b>Mar. 18, 1961</b> , that (I) (we) last saw the deceased alive on <b>Mar. 17, 1961</b> , and that death occurred at <b>11A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Stonesifer</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>		22d. ADDRESS <b>Greensboro, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-21-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>		23d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Bouclair, Greensboro, Md.</b>		25a. REC'D BY REGISTRAR <b>Mar 22 '61</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

0223

CERTIFICATE OF DEATH

1103

(M)

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

2912

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 9 Film G262 3/17/61 mh

02894

1. PLACE OF DEATH a. COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hillsboro</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Georgie</u> Middle <u>Standford</u> Last <u>Standford</u>		4. DATE OF DEATH Month <u>3</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-25-1893</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
13. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		14. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. FATHER'S NAME <u>John Minds</u>		16. MOTHER'S MAIDEN NAME <u>Sarah Minds Jefferson</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO. <u>  </u>	
19. ADDRESS <u>Maggie Rickett, Cordova, Md.</u>		20. INFORMATION	
21. CAUSE OF DEATH [Enter only one cause per line for (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage &amp; Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Arteriosclerotic Cardiovascular Disease with Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		22. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
24a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>		24b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
24c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24d. (City or town) (County) (State)	
25. I certify that (I) (this hospital) attended the deceased from <u>Mar. 3 1961</u> to <u>Mar. 4 1961</u> , that (I) (we) last saw the deceased alive on <u>Mar. 3 1961</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above.		26. SIGNATURE <u>Charles H. Stonesifer</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
27. PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>		28. ADDRESS <u>Greensboro, Md.</u>	
29a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		29b. DATE THEREOF <u>3-7-61</u>	
29c. NAME OF CEMETERY OR CREMATORY <u>SANDTOWN CEM</u>		29d. LOCATION (City, town, or county) (State) <u>Hillsboro Md</u>	
30. FUNERAL DIRECTOR'S SIGNATURE <u>James K. Dabill, Boston, Md.</u>		31. ADDRESS	
32a. REC'D BY REGISTRAR <u>  </u>		32b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>	
33. DATE <u>MAR 14 '61</u>		34. DATE	

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CERTIFICATE OF DEATH

1915



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Page 4  
TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death.  
TO HOSPITAL OR AT HOME: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
2913  
CERTIFICATE OF DEATH

02895

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgley</b>		c. LENGTH OF STAY IN lb <b>2 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>at home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgley</b>	
d. STREET ADDRESS <b>Maple Avenue Ext.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Louise Wilson</b>		4. DATE OF DEATH <b>March 5, 1961</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 27, 1909</b>	
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Howard Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Lenora Stallings</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>ukn</b>	
17. INFORMANT <b>Mr. Norman Wilson, Ridgley, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> 433.1 DUE TO <b>(Cardiac Arrest.)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <b>Paroxysmal Cardiac Arrhythmia</b> (c) <b>Stroke Unknown</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Stroke Unknown</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 HRS</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 19, 1961</b> to <b>May 5, 1961</b> , that (I) (we) last saw the deceased alive on <b>May 4, 1961</b> , and that death occurred at <b>1:05 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Charles H. Winnacott</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Chas H. Winnacott</b>		22d. ADDRESS <b>Ridgley, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/7/61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Easton, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. Hampton Good</b>		25a. REC'D BY REGISTRAR <b>MAR 8 '61</b>	
ADDRESS <b>Easton, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

